STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003776	A. BUILDING: _____ B. WING _____	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH WEST HOSPITAL	1111 N RONALD REAGAN PKWY AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for two (2) State hospital complaints investigation. Complaint: #IN00116900 Unsubstantiated -lack of sufficient evidence. #IN00114097 Unsubstantiated- lack of sufficient evidence. Survey Date: 02/12/13 Facility #: 003776 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor IU Health West Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules. QA: claughlin 03/18/13	S 000		